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ABSTRACT

According to a 1975 survey conducted by the National Clearinghouse for Smoking and Health, attitudes toward smoking are becoming increasingly negative. While studies assessing the impact of counselor smoking on clients suggest that no overwhelmingly harmful impact on clients' perceptions of therapists occurs, the issue of the impact of counselor's smoking on prospective clients remains unresolved. A study was conducted to examine the effect of smoking counselors on the initial impressions of potential clients, both nonsmoking and smoking, and to determine these subjects' expectations of therapeutic gain. Subjects were 27 smoking and 27 nonsmoking female undergraduates who were randomly assigned to conditions and counselors. Subjects viewed a videotape of a male counselor in either a smoking or nonsmoking condition in a counseling session with an off-camera female client. Subjects completed the Counselor Rating Form, a modified Counselor Confidence Ratings form, the Relationship Inventory, and a post-experimental questionnaire. The results revealed that neither the counselor's nor the subject's smoking had any bearing on the subject's judgments concerning the counselor's personal characteristics, subject's expectancies for obtaining help with specific problems, perceived quality of the client-therapist relationship, or subject's judgments of the therapist as an emerging counselor. A review of the literature and the present findings both suggest that therapist smoking has neither a strong nor a negative initial impact on prospective clients. (NB)

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Smokers' and Nonsmokers' Perceptions of Smoking Versus Nonsmoking Therapists

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Presented at the Southwestern Psychological Association meeting, Ft. Worth, TX, 1986.

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Smokers' and Nonsmokers' Perceptions of Smoking

Smoking Versus Nonsmoking Therapists

Recent and significant changes in smoking attitudes and behavior suggest that cigarette smoking is emerging as a deviant behavior. The former Secretary of Health, Education, and Welfare noted this change in his perception of the change in cigarette smoking etiquette. He stated, "Once the smoker asked, 'Would you like a cigarette?' Today the question is, 'Do you mind if I smoke?'" (Markle & Troyer, 1979).

Not only is the scientific community compiling evidence of detrimental effects of smoke on the smoker's health, but research has also indicated that "second-hand smoke" may be hazardous to a nonsmoker's health ("Beware Smoky Rooms", 1980). In the face of such evidence, nonsmokers are obtaining increasing legal support in their attempts to ban or restrict smoking. Since 1973, 32 states have passed legislation limiting smoking in enclosed public areas (Kneeland, 1979). The Center for Disease Control in Atlanta reports that 133 antismoking bills were introduced in 44 states in 1977 (Wald, 1979).

According to a 1975 survey conducted by the National Clearinghouse for Smoking and Health, attitudes toward smoking are growing increasingly negative. Seventy-seven percent of nonsmokers and thirty-five percent of smokers

agree that it is annoying to be near a person smoking cigarettes. Eighty-one percent of the nonsmokers and fifty-one percent of the smokers agree that smoking of cigarettes should be allowed in fewer places than it is now. Eighty-eight percent of the nonsmokers and sixty-three percent of the smokers agree that people in the health professions should set a good example by not smoking cigarettes. Bleda and Sandman (1977) report that nonsmokers rated persons more negatively when they smoked. More favorable emotional responses were shown by nonsmokers exposed to a nonsmoking other rather than to either a courteous (exhaling smoke away from another) or a discourteous (exhaling directly toward another) smoker.

A survey of 130 urban adults conducted by Clark (1978b) dealing with the reactions of individuals to the smoking of others, indicates that all the nonsmokers surveyed reported noticing when others smoke. None of the nonsmokers reported having a positive reaction when someone smokes, and 77% of the nonsmokers reported having a negative reaction. In addition, 54% of the nonsmokers reported that interaction is interrupted or made more distant when others smoke. Of the smokers surveyed, 90% reported noticing when others smoke, however, only 12% reported having a negative reaction, 4% a positive reaction, 51% reported a desire to smoke, and 37% reported

no reaction. Of the smokers, 16% reported that the interaction is interrupted or more distant, 11% reported that they feel closer, and 74% reported interaction is unaffected. Clark (1978a) suggests that involvement in smoking is correlated with a reduction in involvement in an interaction. He hypothesizes that smoking a cigarette allows the smoker an avenue of withdrawal, and thus sees smoking as a means to modulate the degree of appropriate and comfortable levels of involvement in social interactions. The results of his study suggest that smoking occurs when the smoker is relatively passive and/or uninvolved. Gilbert (1980) reports that, "smoking for tranquilization correlated positively with introversion and, similarly, introversion correlated positively with reports of a greater desire to smoke in a stressful, as compared to a non-stressful situation."

Smoking During Therapy

Poussaint, Bergman, and Lichtenstein (1966) investigated the effects of a treating physician's smoking or not smoking in front of patients during treatment to help patients stop smoking. Smoking on the part of the treating physician was unrelated to outcome during the treatment period, drop-out rates, or outcome at follow-up six months after treatment. It should be noted that only during the initial interview did the physician smoke and that the

initial interview was the only extensive interview analogous to a therapy session. Lichtenstein, Ransom, and Brown (1981) reported that the credibility of the rationale for treatment programs to stop smoking and the personal attributes of the programs' counselors were enhanced if the counselors were ex-smokers. No differences emerged between current and never-smoking counselors. The work of Lichtenstein and his colleagues suggests that in some specific counseling situations (i.e., programs to stop smoking) whether the counselor smokes or not has little bearing on the treatment, clients' perceptions of the counselor, or credibility of the treatment program. Possibly these differences simply represent an affirmation of the clinical lore that addicted clients prefer ex-addicts or fellow addicts as counselors because of their shared experiences and consequent ability to empathize (Lichtenstein et al., 1981).

Whether the impact of a counselor's smoking status on smoking-addicted clients is generalizable to other client populations and treatment of nonsmoking problems remains speculative. Evidence bearing directly on this question is lacking, but given the implications of counselor smoking behavior in the context of counseling and interpersonal influence theory it seems reasonable and important to examine the issue empirically. Along related lines,

Tamerin and Eisinger (1972) surveyed psychiatrists concerning their cigarette smoking. Their investigation revealed that: (a) a higher percentage of psychiatrists (42%) smoked than did all other physicians (20%) or other medical specialty groups, (b) psychiatrists were the least successful medical specialty group in quitting smoking, and (c) psychiatrists were more likely to smoke in front of their patients than other medical specialists.

Schneider's (1984, 1985) analogue studies provide additional information. In the first study (Schneider, 1984) female subjects observed a videotaped male counselor given a high or low status introduction. Under each status level, the counselor smoked either a cigarette, a pipe, or refrained from smoking while conducting a simulated interview with an off-camera female confederate client. Afterwards subjects completed Barak and LaCrosse's (1975) Counselor Rating Form (CRF), Atkinson and Carskaddon's (1975) Counselor Effectiveness Rating Scale (CERS), and rated the expectancies of obtaining help for 18 specific problems. No differences among therapist smoking conditions occurred on the CRF. On three of the five CERS concepts nonsmoking counselors received more favorable evaluations than one or both of the smoking counselor conditions. Subjects' expectancies for only three of the 18 specific problems varied as a function of the counselor

smoking conditions (study problem, poor academic performance, drug problems). These differences entailed subjects having lower expectancies for help under the pipe smoking counselor than from one or both of the other counselor smoking conditions (cigarette or nonsmoking).

Schneider (1985) further examined the impact of female smoking or nonsmoking counselors on nonsmoking females. Both smoking and nonsmoking counselors were introduced with feminist, traditional, explicit feminist, or explicit traditional pre-therapy announcements. After viewing a videotaped analogue interview between the counselor and the off-camera female confederate client, subjects completed Corrigan and Schmidt's (1983) short Counselor Rating Form (CRF-S), CERS, and 20 specific counseling expectancies. For the CRF-S only the trustworthy dimension distinguished the counselors. The cigarette smoking counselor was perceived as less trustworthy. No differences between smoking and nonsmoking counselors occurred on the CERS or the list of 20 specific problems.

In summary, results of the studies attempting to assess the impact of counselor smoking on clients suggest that no overwhelming deleterious impact on clients' perceptions of therapists occurs. However, the issue of the impact of counselor's smoking on prospective clients remain unresolved. In Schneider's (1984) study approximately

9% of his subjects were found to be smokers at the post-experimental inquiry. Those participants may have had some bias favoring smoking therapists. Additionally Schneider's (1985) sample was restricted to nonsmokers.

Rationale

The purpose of the present analogue study was to investigate the effect of smoking counselors on the initial impressions of both nonsmoking and smoking potential clients, and to determine these subjects' expectations of therapeutic gain. It was hypothesized that nonsmoking potential clients would: (a) view smoking therapists as less attractive, expert, and trustworthy than nonsmoking therapists, (b) place less confidence in the smoking counselors' than in the nonsmoking counselors' effectiveness in providing help for a variety of personal problems, and (c) view smoking therapists as displaying less empathic understanding, unconditional regard, level of regard, and congruence, while raising subjects' level of resistance. Finally it was expected that smoking potential clients would not respond differentially to smoking and nonsmoking therapists.

Method

Subjects

A total of 413 females responded to a survey distributed to and completed by undergraduate psychology

classes at a large southwestern university. Females who indicated on an item embedded in the survey that they smoked cigarettes constituted the subject pool for the experimental group. Experimental subjects were contacted by telephone and asked if they would be willing to participate in a study to develop new counselor rating scales for researchers and receive research credit for their participation. Control subjects consisted of nonsmoking females from the same classes who volunteered through the general sign-up procedure for receiving research credit in their undergraduate classes. The 27 smoking subjects (mean number of cigarettes reported smoked per day = 13) and 27 nonsmoking subjects were randomly assigned to conditions and counselors resulting in *n* of 13 or 14 subjects per cell. The final sample of 54 females had a mean age of 21.1 years (*SD* = 4.7).

Stimulus Materials

A 15 to 17 minute long script (Cash & Salzbach, 1978) of a counseling interview featuring a female freshman discussing her doubts about her ability to succeed in college served as the stimulus dialogue. The script was edited by deleting two of the personal and two of the demographic counselor disclosures and by changing the geographical references.

A white male doctoral candidate in counseling psychology, age 29, was videotaped twice. In the smoking condition, the role-played counselor lit a cigarette and puffed on the cigarette at seven points during the interview script. In the control condition, the counselor did not smoke but made gestures to his face, using the same hand and at the same points in the dialogue, to control for frequency of hand movements in the smoking condition. In both conditions the counselor projected a sincere and empathic tone.

Only the counselor in a frontal position from the waist-up appeared on the videotape. The same 25 year old, white female doctoral candidate in counseling psychology role-played the client on both tapes, but she remained off camera. The client and counselor rehearsed the script until each tape was as identical as possible with respect to performance, quality, and similarity in all aspects save the smoking variable. Three PhD psychologists judged the tapes comparable in technical quality.

Dependent Measures

Counselor Rating Form (CRF). The CRF (Barak & LaCrosse, 1975) consists of 36 pairs of bipolar adjectives designed to assess client perceptions of counselor expertness, attractiveness, and trustworthiness. Scores for each dimension have a possible range of 12 to 84, with

higher scores indicating greater degrees of perceived counselor skills. Each attribute is represented by twelve 7-point scales. LaCrosse and Barak (1976) report split-half reliabilities of .87, .84, and .90 for the three scales, respectively.

Counselor Confidence Ratings (CCR). The CRR (Cash, Begley, McGown, & Weise, 1975) assesses the degree of confidence subjects place in the counselor's effectiveness with 15 particular types of personal problems. The CCR was modified by (a) replacing career choice with choosing a major and (b) adding four problems: poor academic performance, employment worries, losing grip on reality, and religious conflicts. An 8-point rating scale labeled at the end points where 1 = no confidence and 8 = extreme confidence required subjects to indicate how effective the counselor would be in providing help for each problem.

Relationship Inventory (RI). The RI was developed by Strong, Wambach, Lopez, and Cooper (1979) from Mann and Murphy's (1975) earlier adaptation of the Barrett-Lennard Relationship Inventory (Barrett-Lennard, 1964). The RI consists of 36 items forming an abridged version of the original four Rogerian subscales each with eight items and adds a four-item scale measuring subjects' resistance to the interviewer's remarks. Lopez and Wambach (1982) reported Cronbach alpha internal consistency reliability

coefficients as follows: Empathic Understanding .70; Unconditional Regard .54; Level of Regard .85; Congruence .81; and Resistance .66. The wording of the items was modified for use in perceived rather than actual counselor contact. Subjects indicated their agreement on a 7-point scale (1 = mostly disagree and 7 = mostly agree). Scores for the Resistance subscale have a possible range of 4 to 28, with higher scores indicating greater subject resistance to the counselor. Scores for the remaining subscales range from 8 to 56, with higher scores indicating greater degrees of perceived counselor empathy, unconditional regard, level of regard, and congruence.

Post-experimental Questionnaire. After finishing the above dependent variables, participants were asked several questions, some of which were relevant to the study and some of which were included as fillers. Participants were asked if they smoked and, if so, how many cigarettes per day they smoked. Three questions were included to elicit information on (a) the subjects' optimism that continued counseling with the counselor would be helpful, (b) likelihood that subjects would return for a second interview, and (c) likelihood of recommending counselor to a friend. These ratings employed 8-point scales where 1 = no optimism (or very unlikely) and 8 = extreme optimism (or very likely).

Procedure

Testing was conducted in small groups of two to seven subjects. When the subjects arrived, they were greeted by a female experimenter who informed them that they would observe a videotape of a counselor conducting an interview and then complete several questionnaires concerning their reactions to the counselor. Subjects were informed that their responses would be anonymous and confidential, that they could drop out of the study without penalty, and that they would be debriefed at the conclusion of the experiment. Subjects were informed that the purpose of the study was to develop new counselor rating scales for researchers.

All subjects received the following introduction (adapted from Cash & Salzbach, 1978) regarding the videotape that they were about to see:

> The counselor you are about to see is Paul Larson. He obtained his Ph.D from Columbia University. Besides his private practice, Dr. Larson also teaches graduate-level seminars on psychotherapy and counseling at Stanford University. You will see Dr. Larson conducting an initial psychological counseling session. Are there any questions? Please watch silently and put yourself into the client's place.

Each subject, after viewing the tape, was asked to indicate her first impressions of the therapist by completing the dependent measures. The last form completed was the post-experimental questionnaire, which included the inquiry to assess and confirm the subjects' smoking histories.

Experimental and control subjects were randomly assigned to groups in a 2 (smoking vs. nonsmoking counselors) X 2 (smoking vs. nonsmoking subjects) factorial design until a minimum of 13 subjects per cell was obtained.

Results

Multivariate analyses of variance (MANOVA) were performed on conceptually related sets of dependent measures using Wilk's lambda criterion. Table 1 shows that the 2 X 2 MANOVA on the CRF scales yielded no main effects or interaction. For the CCR MANOVA three subjects failed to

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Insert Table 1 about here

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respond to every item thereby shrinking the n in two cells. Table 1 illustrates that no main effects occurred for the CCR although the interaction approached significance (p = .09). Two subjects failed to complete all RI items reducing n in 2 cells. The MANOVA of the RI scales showed no main effects or interaction (See Table 1).

A final MANOVA was performed on the three post-experimental questions asking participants their impressions regarding their: (a) optimism about continuing counseling with the therapist, (b) likelihood of returning for a second interview, and (c) likelihood of recommending the therapist to a friend. Table 1 shows no main effects or interaction achieved statistical significance.

Discussion

In the present analogue, participants with smoking and nonsmoking personal histories judged a videotaped smoking or nonsmoking counselor while interviewing a pseudoclient. Neither the counselor's nor subjects' smoking had any bearing on participants' judgments concerning the counselor's personal characteristics, subjects' expectancies for obtaining help with specific problems, perceived quality of the client-therapist relationship, or subjects' judgments of the therapist as an engaging counselor.

Considered with previous analogue research (Schneider, 1984; 1985), there seems to be little reason to believe that therapist smoking influences clients' impressions of therapist personal characteristics. Expertness was the only CRF dimension affected by therapist smoking in Schneider's (1985) investigation--and that study employed a female therapist. Thus any negative consequences may be

related to the sex pairing of the therapist-client dyad. Further study will need to clarify this possibility.

No differences emerged on the CCR in the present study, contrary to Schneider's (1984) investigation. However, in that study, differences on the CCR involved the therapist who smoked a pipe. No differences occurred between the cigarette smoking and nonsmoking therapist. This raises the possibility that clients may react differentially as a function of the counselor's smoking implement.

Given the current anti-smoking zeitgeist, one wonders why participants did not form stronger, consistent, negative impressions of smoking therapists. One must bear in mind that the current study was only involved with social-psychological impressions. No attempt was made to have subjects address or evaluate directly physiological implications of smoking or exposure to secondary smoke. Possibly subjects distinguish quite well between physiological and social-psychological dimensions of smoking. While smoking may not bother them with respect to the latter dimension, they could remain quite sensitive to smoking's physiological implications.

Another possibility might be inherent to the analogue. Using a videotape mode of counselor presentation deprives subjects of olfactory and other physical cues which may be

relevant or critical to formation of negative impressions. An analogue approaching a more realistic counseling situation would be necessary to understand the role of such cues, although Poussaint et al.'s (1966) investigation suggests that such cues would make little difference.

Another possibility suggests that initial impressions might not be stable over the course of treatment. Consequently if the therapist smokes throughout the course of therapy, the client's positive impressions of the therapist could diminish. This would seem a difficult problem to resolve since client gains in therapy (e.g., improvement in initial levels of cynicism, general level of frustration, etc.) could result in greater readiness or inhibition to control expression of one's reactions.

The issues remain complex and the results might possibly run counter to the current zeitgeist. Yet from the literature reviewed and the present findings little convincing evidence emerges, at least on the social-psychological level, that therapist smoking has either a strong or a negative initial impact on prospective clients.

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Table 1

MANOVA *F* Values for Dependent Measures

Scale	Therapist Smoking (A)	Subject Smoking (B)	A X B
CRF	.761[1]	.358[1]	.603[1]
CCR	1.15[2]	.815[2]	1.72[2]
RI	1.15[3]	1.61[3]	.546[3]
Post-experimental Questionnaire	1.21[1]	1.96[1]	1.33[1]

[1] *df* = 3, 49; [2] *df* = 19, 30; [3] *df* = 5, 45;